PATIENT INTAKE FORM

PATIENT INFORMATION

Patient Name_____
Last Name

_____
First Name Middle Initial

Date_____ Nickname_____

Address_____

City_____State_____Zip_____

E-mail_____

Phone Number_____

Birthdate_____Age____Sex_____

Employer/School_____

Occupation_____

In case of emergency, contact…

Name_____

Relationship_____

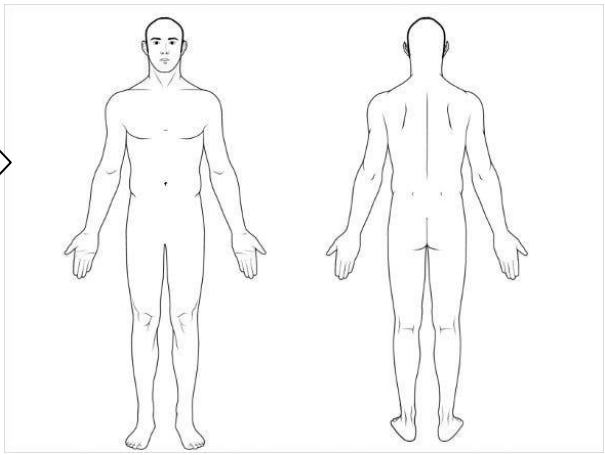
Phone Number_____

PATIENT CONDITION

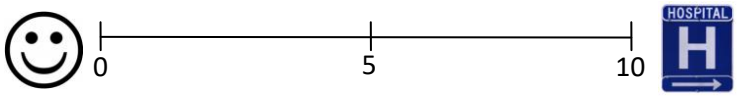
Reason for Visit_____

When did symptoms appear?_____

Mark an X where there is pain, numbness, or tingling



Rate the severity of your pain:



Type of pain:

☐ Sharp ☐ Achy ☐ Throbbing ☐ Shooting ☐ Numbness

☐ Burning ☐ Tingling ☐ Spasm ☐ Other ☐ Stiffness

Is it constant or intermittent? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Recreation ☐ Daily Routine

Activity that is painful to perform ☐ Sitting ☐ Standing ☐ Bending ☐ Walking ☐ Lying Down

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other

Other doctors who have treated you for your condition _____

Date of Last Relevant: Physical Exam _____ Spinal Exam _____Chest X-Ray _____

Spinal X-Ray _____ MRI, Bone, or CT-Scan _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

HEALTH HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐Yes ☐No	Fractures	☐Yes ☐No	Parkinson's Disease	☐Yes ☐No
Alcoholism	☐Yes ☐No	Glaucoma	☐Yes ☐No	Pinched Nerve	☐Yes ☐No
Allergy Shots	☐Yes ☐No	Goiter	☐Yes ☐No	Pneumonia	☐Yes ☐No
Anemia	☐Yes ☐No	Gonorrhea	☐Yes ☐No	Polio	☐Yes ☐No
Anorexia	☐Yes ☐No	Gout	☐Yes ☐No	Prostate Problem	☐Yes ☐No
Appendicitis	☐Yes ☐No	Heart Disease	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Arthritis	☐Yes ☐No	Hepatitis	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No
Asthma	☐Yes ☐No	Hernia	☐Yes ☐No		
Bleeding Disorders	☐Yes ☐No	Herniated Disk	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
		Herpes	☐Yes ☐No	Stroke	☐Yes ☐No
Breast Lump	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Suicide Attempt	☐Yes ☐No
Bronchitis	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Bulimia	☐Yes ☐No	Liver Disease	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Cancer	☐Yes ☐No	Measles	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Cataracts	☐Yes ☐No	Migraines	☐Yes ☐No	Tumors, Growths	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Miscarriage	☐Yes ☐No	Typhoid Fever	☐Yes ☐No
		Mononucleosis	☐Yes ☐No	Ulcers	☐Yes ☐No
Chicken Pox	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No	Vaginal Infections	☐Yes ☐No
Diabetes	☐Yes ☐No	Mumps	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Emphysema	☐Yes ☐No	Osteoporosis	☐Yes ☐No	Whooping Cough	☐Yes ☐No
Epilepsy	☐Yes ☐No	Pacemaker	☐Yes ☐No	Other _____	

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Wk _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress	Reason _____

INJURIES/SURGERIES	MEDICATIONS	ALLERGIES
Description Date		
Falls _____		
Head Injuries _____		
Broken Bones _____		
Dislocations _____		
Surgeries _____		